# OPTIMA HEALTH PLAN

## PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

**Directions**: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

**Drug Requested: Sucraid®** (sacrosidase)

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Form/Strength:** _____

**Dosing Schedule**: _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Quantity Limit:** 236mL/30 days

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Initial Approval: 60 days**

- ❑ Patient is 5 months of age or older and has a diagnosis of congenital sucrase-isomaltase deficiency (CSID) confirmed by a gastroenterologist, endocrinologist, or genetics specialist

**AND**

- ❑ Patient has documented chronic symptoms of CSID including watery diarrhea, abdominal pain, gas/bloating after sucrose/starch ingestion (must submit chart notes documenting symptoms following sucrose/starch ingestion)
  - Number of severe GI events within the last 2 months: _____ **(must be documented in submitted chart notes)**

**AND**

- ❑ A low sucrose and low starch diet has been attempted with improvement in patient symptoms, and patient will continue to follow a low sucrose, low starch diet while on therapy

**AND**

- ❑ Patient does not have lactose intolerance or a secondary sucrase deficiency associated with any of the following: celiac disease, Crohn's disease, autoimmune gastroenteropathy, eosinophilic gastroenteropathy, short bowel syndrome, Giardiasis, small intestinal bacterial overgrowth (SIBO), acute gastroenteritis, or enteropathy associated with acquired immune deficiency syndrome

**(Continued on next page)**

**AND (ALL 4 below MUST be met):**

| | |
|---|---|
| ❑ Stool pH < 6.0 | ❑ Increase in breath hydrogen of > 10 ppm when challenged with sucrose after fasting |
| ❑ Genetic test results confirm diagnosis of CSID | ❑ Negative lactose breath test |

**OR (BOTH below MUST be met)**

- ❑ Small bowel biopsy documents intestinal sucrase activity of <25 U/g protein (must be greater than 2 standard deviations below the mean) with normal or decreased maltase and isomaltase levels, normal levels of other disaccharides, and normal villous architecture of the small intestine on biopsy
- ❑ Genetic testing results document sucrase-isomaltase deficiency (CSID)

**Reauthorization Approval: 12 months.** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Patient has had a 50% reduction in all symptoms of CSID, including watery diarrhea, abdominal pain, gas/bloating; etc. **(improvement from baseline must be noted in submitted chart notes)**
  - Number of severe GI events within the last 2 months: _____ **(must be documented in submitted chart notes)**

**AND**

- ❑ Patient will continue to follow a low sucrose, low starch diet while on therapy

**Medication being provided by Specialty Pharmacy - PropriumRx**

***Not all drugs may be covered under every Plan***

***If a drug is non-formulary on a Plan, documentation of medical necessity will be required.***

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

**DEA OR NPI #:** _____

***Approved by Pharmacy and Therapeutics Committee**: ~~1/15/2015;~~ 8/20/2020
**REVISED/UPDATED:** ~~1/26/2015; 5/22/2015; 12/29/2015; 12/20/2016; 8/18/2017; 12/30/2018; (Reformatted) 6/19/2019;~~ **11/12/2020**